NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

5220 SPRING VALLEY ROAD, SUITE 400
DALLAS, TEXAS 75240

ORGAN TRANSPLANT INSURANCE POLICY

THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE
PREMIUMS MAY BE INCREASED UPON RENEWAL

This Policy is guaranteed renewable for life if you pay the premium when due or within the Grace Period. If you pay the premium on time, we cannot cancel the Policy or place any restrictions on it. We may change the premium rates for this Policy as stated in the Renewal Premiums provision.

IMPORTANT NOTICE! PLEASE READ!

This Policy was issued based on your answers to the questions in your Application. A copy of your Application is attached and is a part of this Policy. Please read it and check to see that the information is correct and complete. If any requested medical history has been left out, or if there is an error, please notify us immediately. If your answers are incorrect or untrue, we have the right to deny benefits, reform or void your Policy, subject to the Incontestable provision. The best time to clear up any misunderstanding is now, before a claim arises!

10-DAY RIGHT TO EXAMINE POLICY

PLEASE READ YOUR POLICY CAREFULLY - THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND US. If you are not satisfied for any reason, return the Policy to us within 10 days after you receive it. We will refund your premium and the Policy will be void.

This Policy is signed for us by our President and Secretary.

Raymond J. Martin, Jr.
President

Rhonda Hayes
Secretary

Countersignature of Licensed Resident Agent (if required by law)

THIS IS A LIMITED BENEFIT POLICY. READ IT CAREFULLY. EXCEPT AS PROVIDED IN THE "TERMINATION OF COVERAGE" AND "TERMINATION FOR NONPAYMENT OF PREMIUM" PROVISIONS, WE WILL PROVIDE BENEFITS FOR EXPENSES INCURRED ONLY WHILE THIS POLICY IS IN FORCE.

SCHEDULE PAGE

10/01/98

THIS SCHEDULE PAGE CONTAINS IMPORTANT BENEFIT PLANS YOU HAVE SELECTED AND THE PREMIUM AMOUNT FOR THOSE PLANS.

FORM	DESCRIPTION			MONTHLY PREMIUM FAMILY
BASE POLICY SELECTED:				
GRT-4001 (6/95)	**ORGAN TRANSPLANT INSURANCE POLICY - PLAN A**			**10.50**
	Human Bone Marrow Transplant Benefit	$	50,000	
	Human Kidney Transplant Benefit	$	50,000	
	Human Liver Transplant Benefit	$	50,000	
	Human Lung Transplant Benefit	$	50,000	
OPTIONAL RIDERS:				
GR-1085 (10/96)	**RETURN OF PREMIUM CASH VALUE RIDER**			**5.25**

COVERED PERSONS

Name	Original Coverage Effective Date	Name	Original Coverage Effective Date
LINDA M FREEMAN	11/01/1998	LARRY FREEMAN	11/01/1998
JOSH FREEMAN	11/01/1998	ZACHARY FREEMAN	11/01/1998

MODE OF PAYMENT:	Monthly Payroll Deduction		**15.75**

Policy Number: T2299
Insured: LINDA M FREEMAN
Owner: LINDA M FREEMAN
7509 LOT 1 OLD SPANISH TRAIL
JEANERETTE LA 70544-0000

Issue Date: 11/01/98
Plan Effective Date: 11/01/98

Rider(s) Effective Date:
ROP Rider 11/01/98
POLICY ENDORSEMENT

INSURING PROVISION

We agree to pay you the benefits provided by this Policy, subject to its definitions, provisions, exclusions and limitations.

CONSIDERATION

We have issued this Policy in consideration of your Application and payment of the first premium on or before the Issue Date.

Coverage begins on the Issue Date at 12 noon, Central Standard time. The Policy will remain in force for any period for which the premium is paid when due or during the Grace Period. If the Policy terminates due to nonpayment of premium, it will terminate at 12 noon, Central Standard time, on the Renewal Date, subject to the Grace Period.

DEFINITIONS

This section provides the meaning of special terms used in this Policy.

CANCER. A disease, including Hodgkin's Disease and Leukemia, which is manifested by the presence of a malignant tumor or disorder characterized by the uncontrolled and abnormal growth and spread of malignant cells and the invasion of normal tissue.

Such cancer must be positively diagnosed by a Doctor certified by the American Board of Pathology or the American Osteopathic Board of Pathology upon the basis of microscopic examination of fixed tissue or preparations from the hemic system (either during life or postmortem). If a positive diagnosis of cancer cannot be made, clinical diagnosis will be accepted, provided that the medical evidence substantially documents the diagnosis of cancer and definitive treatment for cancer is initialed on the basis of the diagnosis.

"Cancer" does not include premalignant conditions or conditions with malignant potential.

CHILD or CHILDREN. Unless specifically excluded from coverage, as indicated on your Application or on any endorsement to this Policy, "Child" or "Children" means your unmarried children, stepchildren and adopted children who are chiefly dependent on you for support and maintenance and who are:

1. Under age 19; or
2. Under age 25 and enrolled as full-time students in an accredited school, college or university if insured prior to age 19.

"Adopted children" shall mean children adopted by you, regardless of whether a final decree of adoption has been entered, provided that a petition has been duly filed and is pursued to a final decree of adoption. "Children" includes children born or adopted by you after the Issue Date who meet the conditions above.

COVERED PERSON. "Covered Person" means only the persons included in the type of Plan you selected on your Application:

1. An "Individual Plan" means only you.
2. A "One Parent Plan" means you and your Children.
3. A "Family Plan" means you, your spouse as of the time of your Application and your Children.

DIRECT CHARGES. "Direct Charges" means the actual charges for Medically Necessary care and treatment incurred by a Covered Person directly and proximately in connection with the Organ Transplant. Direct and proximate expenses are those expenses which would not have been incurred except for the Organ Transplant. Direct Charges must result in an Organ Transplant and must be incurred during the 365 days before or after the Organ Transplant. Such charges include reimbursement of any medical expense for the live donor to the extent that benefits remain and are available under this Policy, after benefits for the Covered Person's own expenses have been paid.

DOCTOR. "Doctor" means a medical practitioner who is:

1. Duly licensed by the state in which he or she practices; and
2. Acting within the scope of his or her license.

"Doctor" does not include you, your spouse, your parents or stepparents, your in-laws, your brothers or sisters, your stepbrothers or stepsisters, your Children, or your grandchildren.

FIRST MANIFESTED. The disease or injury resulting in an Organ Transplant is first manifested when:

1. The disease or injury which results in an Organ Transplant is first positively diagnosed by a Doctor based upon generally accepted clinical and laboratory criteria; or
2. Symptoms are indicative of a disease or injury resulting in an Organ Transplant which

LUNG TRANSPLANT BENEFIT, WILL BE PAID IN ADDITION TO ANY OTHER POLICY OF THIS COMPANY.

EXCLUSIONS AND LIMITATIONS

In addition to any other exclusions, exceptions or limitations described in the Policy, no benefits are provided for services or supplies that are not Medically Necessary. **No benefits will be provided for the following, regardless of medical necessity:**

1. Care or treatment received outside of Canada or the United States or its possessions.
2. Care or treatment rendered after termination of your coverage except as provided in the Policy section entitled, "TERMINATION FOR NONPAYMENT OF PREMIUM".
3. injuries intentionally inflicted or attempted suicide by self or any other family member (in either case, whether sane or insane).
4. Injuries sustained while committing, or attempting to commit, a felony or while engaging in an illegal occupation.
5. Due to alcoholism, drug addiction or chemical dependency.
6. Due to war or any act of war, whether declared or not, or riot or civil commotion, or service in the armed forces or units auxiliary thereto.

PREEXISTING CONDITIONS LIMITATION

This Policy and any Riders attached to it do not cover any Organ Transplant resulting from a preexisting conditions for the first 2 years after their Issue Date.

"Preexisting Condition" means a condition for which:

1. Medical advice or treatment was recommended by or received from a Doctor within the 1-year period before the Issue Date in connection with any disease or injury resulting in an Organ Transplant; or
2. Symptoms existed within the 1-year period before the Issue Date indicative of a disease or injury resulting in an Organ Transplant that would cause an ordinarily prudent person to seek diagnosis, care or treatment.

Persons or conditions excluded in the Application are never covered unless there is an amendment attached to the Policy that waives the exclusion. This preexisting condition limitation does not apply to a Child born to you after this Policy is in force if Children are included as Covered Persons under the Plan selected on your Application or subsequent endorsements to the Policy.

PREMIUMS

PAYMENT OF PREMIUM. You may continue this Policy to the next Renewal Date by timely payment of premiums. All premiums are to be paid to us and are due in advance of the period they are to cover. The premiums for this Policy may change as stated in the RENEWAL PREMIUMS provision.

REFUND OF PREPAID PREMIUMS. If we are notified of your death, we will refund any prepaid premium for any period beyond the end of the month in which your death occurred.

RENEWAL PREMIUMS. Renewal premiums will be at the premium rates in effect on each Renewal Date. We may change the premium rates for this Policy. If we do change the premium rates, we will do so only if we change the premium rates for all policies in the same class and in the same state as this Policy. In addition, we will notify you in writing at your last known address at least 31 days before the change becomes effective.

TERMINATION OF COVERAGE

TERMINATION FOR NONPAYMENT OF PREMIUM. The coverage for all Covered Persons will end on the Renewal Date if the required premium is not paid when due or within the 31-day Grace Period. No further benefits will thereafter be available for any Covered Person except for Direct Charges incurred during a continuous hospital confinement that begins before the coverage ended and ends after the coverage has terminated.

GRACE PERIOD. This Policy has a 31-day grace period. This means that if a premium is not paid on or before the date it is due, it may be paid during the 31 days following the due date. During the Grace Period, this Policy will stay in force.

REINSTATEMENT. If the renewal premium is not paid before the Grace Period ends, the Policy will lapse as of the Renewal Date. After the Policy lapses, if we accept premium but do not require you to complete an application for reinstatement, we will

the spouse must complete an application and pay any required premium before the spouse's coverage under this Policy ends. The new policy will be issued without requiring evidence of good health. We will use a policy form we are offering in the spouse's state of residence which is most similar to this Policy, or one which contains lesser coverage, and the new policy will contain any limitations contained in this Policy for the spouse. All waiting periods that have been satisfied under this Policy will be considered as being met under the new policy. Coverage under the new policy will begin on the date next following the date the spouse's coverage terminates under this Policy. At the option of the spouse, any Children covered under this Policy (for whom the spouse has the legal obligation of support) may also be converted to the new policy. Conversion for any Children is subject to the same conditions as the spouse's conversion.

CONTINUATION OF POLICY AFTER YOUR DEATH. In the event of your death, the other Covered Persons insured under this Policy have the right to continue their coverage by paying the required premium when due or within the Grace Period.

CLAIM PROVISIONS

NOTICE OF CLAIM. Written notice of claim must be given to us within 30 days after a covered loss starts or as soon as reasonably possible. The notice must be given to us at our Home Office. Notice should include your name and Policy number. *WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.*

CLAIM FORMS. When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days after we receive your notice, you will meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss. We must receive this statement within the time limit stated in the PROOF OF LOSS section.

PROOF OF LOSS. Written proof of loss must be furnished to us within 90 days after we receive notice of claim. We will not deny or reduce any benefit because we are not furnished proof in the time required if it is not possible for you to do so. However, proof must be furnished as soon as reasonably possible, and in no event later than 12 months from the time proof of loss would otherwise be required unless legally incapacitated.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION. If necessary to determine our liability, as part of proof of loss, we may require proof of eligibility, itemized bills stating the extent of loss, and other information that might affect our liability. We may request you to authorize release of medical data from providers of medical services and from other sources from whom you have claimed benefits. If any information is not furnished or the release of data is not authorized, we reserve the right to withhold benefits.

TIME OF PAYMENT OF CLAIMS. Benefits payable under this Policy will be paid as soon as we receive proper written proof of loss.

PAYMENT OF CLAIMS. We will pay all benefits to you, unless assigned, as stated in the ASSIGNMENT provision. If any accrued benefits are unpaid at your death, we may pay them to your spouse, if living, otherwise to your estate.

CLAIM APPEAL PROCESS. Our practice is to treat each claim submission fairly, based on the facts we are provided. You may have additional information that could change a claim decision. To provide a full and fair review, we have established an appeal process in the event you want to appeal or review a claim decision. You will be notified of your right to appeal and the appeal process at the time an initial claim decision is made.

PHYSICAL EXAMINATION AND AUTOPSY. At our expense, we have the right to have a Covered Person examined as often as reasonably necessary while a claim is pending and, where it is not prohibited by law, to require an autopsy when death occurs.

LEGAL ACTION. No legal action may be brought to recover on this Policy within 60 days after written proof of loss has been given as required by this Policy. No action may be brought after the expiration of the applicable statute of limitations from the time written proof of loss is required to be given.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES. This Policy, including the Application and any attachments and Riders, is the entire contract between you and us. No change in this Policy will be valid until approved, in writing, by one of our executive officers and the approval has been forwarded to you for attachment to your Policy. No other person has the authority to change this Policy or to waive any of its provisions.


NTA

NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY
5220 Spring Valley Road, Suite 400 • Dallas, Texas 75240

POLICY CHANGE ENDORSEMENT

The paragraphs listed in this Endorsement and referred to in policy GRT-4001 (6/95) are amended in their entirety to read as follows:

Page 5 DEFINITIONS

CHILD or CHILDREN. Unless specifically excluded from coverage, as indicated on your Application or on any endorsement to this Policy, "Child" or "Children" means your unmarried children, stepchildren and adopted children who are chiefly dependent on you for support and maintenance and who are and grandchildren, who reside with you, are in your legal custody and who are chiefly dependent on you for support and maintenance, and all of whom are:

1. Under age 21; or
2. Under age 25 and enrolled as full-time students in an accredited school, college or university if insured prior to age 21.

"Adopted children" shall mean children adopted by you, regardless of whether a final decree of adoption has been entered, provided that a petition has been duly filed and is pursued to a final decree of adoption. "Children" includes children born or adopted by you after the Issue Date who meet the conditions above.

Page 7 PREMIUMS

RENEWAL PREMIUMS. Renewal premiums will be at the premium rates in effect on each Renewal Date. We may change the premium rates for this Policy. If we do change the premium rates, we will do so only if we change the premium rates for all policies in the same class and in the same state as this Policy. We can increase premium rates no more than once in the first 12 months and then no more frequently than once in any 6 month period. In addition, we will notify you in writing at your last known address at least 45 days before the change becomes effective.

This Endorsement is subject to all of the Policy definitions, provisions, exceptions and limitations which are not inconsistent with the provisions of this Endorsement.

IN WITNESS WHEREOF, we have caused this Endorsement to be signed effective as of the Policy Issue Date.

President Secretary

FORM APPROVED
JAMES H. "JIM" BROWN
COMMISSIONER OF INSURANCE
AUG 07 1995

75-204-LA

NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY
5220 SPRING VALLEY ROAD, SUITE 320 ■ DALLAS, TEXAS 75240

RETURN OF PREMIUM - CASH VALUE RIDER

NOTICE. This Rider is a part of the Policy to which it is attached and is subject to all of the Policy definitions, provisions, exceptions and limitations that are not inconsistent with the provisions of this Rider. The effective date of this Rider shall be the Issue Date of the Policy unless a different effective date is shown on the Schedule Page of the Policy. All Rider years and anniversaries shall be computed from the effective date of this Rider. This Rider is issued in consideration of the application therefor, a copy of which is attached to and made a part of the Policy, and the payment in advance of the premiums specified for this Rider on the Schedule Page of the Policy.

DEFINITIONS

Claims. Any claims paid, or incurred but not paid during the Covered Period, including Waiver of Premium, under the Policy or any Rider for all Covered Persons.

Premiums. All premium amounts actually paid for the Policy and any Rider during the Covered Period. The premium amount includes (i) the original premium rate in effect on the Rider effective date, (ii) any adjustments of the Plan selected at the time of application, (iii) any premium increases, and (iv) any premiums waived in accordance with the Waiver of Premium clause of the Policy. This premium amount may not exceed the number of years included in the Covered Period times the annual premium, including any increases, for the Policy and any Rider in effect on the Rider effective date.

Covered Period. The time from the effective date of the Rider to the date of termination of this Rider.

BENEFITS

25th Year Benefit. After this Rider has been in force 25 or more consecutive years following the effective date of this Rider, we will pay the Policyowner upon request a one-time benefit of 100% of the Premiums paid during the Covered Period, less all Claims paid or payable during the Covered Period.

Withdrawal Benefit. After this Rider has been in force for more than 5 consecutive years, upon request we will pay the Policyowner a one-time cash value benefit upon surrender of the Policy. If payment of the one-time cash value benefit has not been requested, we will pay the cash value benefit if (1) the Policy lapses, or (2) the Insured dies. The cash value benefit is equal to the Premiums paid during the Covered Period times the applicable Cash Value Factor shown in the table below, less all Claims paid or payable during the Covered Period.

Any Premiums waived in accordance with the Waiver of Premium clause of the Policy shall be considered as Premiums paid and as Claims paid. The Cash Value Factors listed below assume that Premiums have been paid for the full year and will be linearly interpolated within a rider duration for any partial year coverage.

CASH VALUE FACTORS

The Cash Value Factors for each Rider year are as follows:

End of Rider Year	Cash Value Factor	End of Rider Year	Cash Value Factor
6	12.70%	16	67.20%
7	22.20%	17	70.90%
8	29.90%	18	74.50%
9	36.30%	19	78.10%
10	41.90%	20	81.70%
11	46.90%	21	85.30%
12	51.40%	22	88.90%
13	55.60%	23	92.60%
14	59.60%	24	96.30%
15	63.50%	25	100.00%

The Cash Value Factors assume that Premiums have been paid for the full year and will be linearly interpolated within a rider duration for any partial year coverage.

RIDER TERMINATION DATE

This Rider will terminate when one or more of the following occurs.

1. When we pay any benefit under this Rider.
2. When any premium for this Rider is not paid before the end of the Grace Period.
3. When we receive written notification to terminate this Rider.
4. When the Policy terminates or is surrendered.

The Rider premium stops when the Rider terminates.

The Company has caused this Rider to be executed for us by our

Raymond J. Martin, President — Rhonda G. Hays, Secretary

NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY
4949 Keller Springs Road • Addison, Texas 75001-5910
972/532-2100 • Fax 972/532-2194
www.ntalife.com

September 17, 1999

Linda Freeman
7509 Lot 1 Old Spanish Trail
Jeanerette, LA 70544

RE: Policy Number(s) **T2299**

Dear Ms. Freeman:

Enclosed is the documentation which reflects the plan change under your referenced policy(s). The effective date of this change is indicated on your new schedule pages.

Please review all information to verify its accuracy. If any inaccuracies are discovered, contact Policy Owner Services immediately, at 1-800-825-5682. Place these documents with your original policy as permanent records.

Again, we are especially glad to serve you, and continue to pledge you "Number One" service to merit your confidence and friendship.

Sincerely,

POLICY OWNER SERVICES

PAH/PLANCHG

Enclosures

SCHEDULE PAGE

REVISED DATE: 9/13/99

THIS SCHEDULE PAGE CONTAINS IMPORTANT BENEFIT PLANS YOU HAVE SELECTED AND THE PREMIUM AMOUNT FOR THOSE PLANS.

FORM	DESCRIPTION			MONTHLY PREMIUM FAMILY
BASE POLICY SELECTED:				
GRT-4001 (6/95)	**ORGAN TRANSPLANT INSURANCE POLICY - PLAN AA**			**20.40**
	Human Bone Marrow Transplant Benefit	$	100,000	
	Human Kidney Transplant Benefit	$	100,000	
	Human Liver Transplant Benefit	$	100,000	
	Human Lung Transplant Benefit	$	100,000	
OPTIONAL RIDERS:				
GR-1085 (10/96)	**RETURN OF PREMIUM CASH VALUE RIDER**			**10.20**

COVERED PERSONS

Name	Original Coverage Effective Date	Name	Original Coverage Effective Date
LINDA M FREEMAN	11/01/1998	LARRY FREEMAN	11/01/1998
JOSH FREEMAN	11/01/1998	ZACHARY FREEMAN	11/01/1998

MODE OF PAYMENT: Monthly Payroll Deduction **30.60**

Policy Number: T2299
Insured: LINDA M FREEMAN
Owner: LINDA M FREEMAN
7509 LOT 1 OLD SPANISH TRAIL
JEANERETTE LA 70544-0000

Issue Date: 11/01/98
Plan Effective Date: 9/01/99

Rider(s) Effective Date:
ROP Rider 9/01/99
POLICY ENDORSEMENT

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF LOUISIANA

LAFAYETTE-OPELOUSAS DIVISION

LARRY FREEMAN AND LINDA M. FREEMAN	:	CIVIL ACTION NO. 6:04cv0961
	:	JUDGE REBECCA DOHERTY
VS.	:	
	:	MAGISTRATE JUDGE MILDRED METHVIN
NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY	:	

Affidavit of John Ruth

1. I am the Vice President and Director of Claims for National Teachers Associates Life Insurance Company ("National").

2. As Vice President and Director of Claims, I have personal knowledge of all documents and communications exchanged between Larry and Linda Freeman and National concerning Organ Transplant Policy number T00002299 issued to Linda Freeman effective November 1, 1998.

3. On September 20, 2002, National received a proof of loss which was submitted by Linda Freeman. A true and correct copy of such proof of loss is attached hereto as Exhibit "1."

4. Exhibit "1" reflects that Larry Freeman underwent a kidney transplant in April of 2002.

5. The foregoing information is from my personal knowledge.

John Ruth

THUS DONE, READ AND PASSED in Dallas, County of Dallas, Texas, this 13th day of January, 2005.

NOTARY PUBLIC IN AND FOR THE STATE OF TEXAS

ANGELA J. MERMON Notary Public, State of Texas My Commission Expires 05-02-06

Printed Name of Notary: Angela J. Mermon

My commission expires on 05/02/06.

[redacted]

National Teachers Associates
Life Insurance Company
Attn: Claims Department
P.O. Box 2369 • Addison, TX 75001-2369
(972) 532-2100 • (800) 825-5682 • FAX: (972) 532-2192

List Policy Numbers Here
T 2299

CLAIMANT'S STATEMENT

INSTRUCTIONS FOR FILING PROOF OF LOSS

1. Complete all items that are applicable, then sign and date the form. Unanswered items will generally cause a delay in processing.
2. Policyholder must sign if the patient is under age 18.
3. Have your doctor complete the *Attending Physician's Statement* or submit an acceptable substitute.
4. On a disability claim, the *Employer's Statement* and the *Attending Physician's Statement* must both be completed.
5. You must submit itemized bills for each benefit claimed (e.g. itemized hospital bill, doctor bills, anesthesiologist bills, etc.)
6. All claims on cancer policies must be supported by a pathology report. (If a pathological diagnosis cannot be made, a clinical diagnosis is acceptable.)

Warning: *Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.*

POLICYHOLDER & PATIENT INFORMATION

Name of Policyholder: LINDA FREEMAN	Social Security Number: 439-19-7609	Occupation: TEACHER	
Address: 7509 LOT 1 OLD SPANISH TRAIL	City: JEANERETTE	State: LA.	Zip: 70544
E-mail address:	Phone Day: (337) 276-6038 Evening: (337) 276-6620	Fax: (337) 276-5016	
Name of Patient: LARRY O. FREEMAN	Patient's Social Security Number: 435-62-9418	Relationship to Policyholder: HUSBAND	
Patient's Date of Birth: 1/5/42	Patient's Height: 6 ft. 0 in.	Patient's Weight: 184 lbs.	Patient's Sex: ☒ M ☐ F
Patient's Phone Day: (337) 276-6620 Evening: (337) 276-6620			
Name of Patient's Primary Physician: DR. CATHERINE STAFFELD	Address: 1514 JEFFERSON HWY. City: NEW ORLEANS, LA.	State: LA.	Zip: 70121
Phone: (504) 842-3925 Fax: ( )			

HISTORY OF PRESENT ACCIDENT • DISABILITY • ILLNESS

☐ **IF ACCIDENT/INJURY**
Date of accident/injury: _____ at _____ a.m. / p.m.
How did the accident/injury occur? _____
Where did the accident/injury occur? N/A
Describe injuries: _____

N. T. A.
RECEIVED
SEP 20 2002
CLAIMS DEPARTMENT

☐ **IF DISABLED**
From N/A through _____.
Date you last worked: _____. Date you are capable of resuming work: _____.

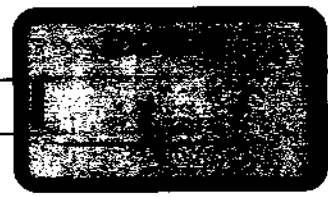
☐ **IF SICKNESS**
Date of sickness: APRIL 15, 2002 at _____ a.m. / p.m. When did symptoms first appear? _____.
Nature of sickness: KIDNEY TRANSPLANT
Has patient ever had the same or similar condition? ☐ Yes ☐ No If "Yes" give details.
Date: _____ Reason: _____ Doctor: _____ Hospitalized? ☐ Yes ☐ No
Has patient been treated for anything else within the past two years? ☐ Yes ☒ No If "Yes" give details.
Date: _____ Reason: _____ Doctor: _____ Hospitalized? ☐ Yes ☐ No
Date: _____ Reason: _____ Doctor: _____ Hospitalized? ☐ Yes ☐ No

☐ **IF WELLNESS BENEFIT** (Attach copy of statement showing procedure and charge)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, The Medical Information Bureau, or other organization, institution, or person, that has any records or knowledge of me or of any member of my family, or my (our) health, to furnish to National Teachers Associates Life Insurance Company of Addison, Texas or its representative, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital, medical records or billing records. A photostatic copy of this authorization shall be considered as effective and valid as the original. I **represent that the information above is true and correct.**

(Signed) Patient Larry Freeman Date 9, 12, 02

(Signed) Policyholder Linda Freeman Date 9, 12, 02



75-101L (9/01)

HEALTH INSURANCE CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

Symptom (if sickness) or Date of Injury: 2 / 4 / 2002	Date first consulted for this condition: 10 / 16 / 2001	Has patient ever had same or similar symptoms? ☐ Yes ☒ No Date: / /
Name & Address of Referring Physician: Catherine Staffeld-Coit 1514 Jefferson Hwy New Orleans, LA 70121		
Name & Address of Hospital where services rendered (if applicable): Ochsner Clinic Foundation 1514 Jefferson New Orleans, LA 70121	Admitted: 4 / 14 / 02	Discharged: 4 / 19 / 02
Diagnosis or Nature of Sickness or Injury: ESRD 2° to glomerulonephritis Cad. Kidney Transplant 4/15/02	ICD-9 Code: 585 V42.0	

Date of Service	Place of Service	CPT Code	Describe Medical Procedures and Services Provided	ICD-9 Code	Charges
			Contact Billing Dept.		

For Disability Claims also complete this section

Physical Impairment (As defined in the Federal Dictionary of Occupational Titles)
- ☐ Class 1 - No limitation of functional capacity; capable of heavy work. No restrictions. (0-10%)
- ☐ Class 2 - Medium manual activity. (15-30%)
- ☐ Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)
- ☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)
- ☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)

N. T. A.
RECEIVED
SEP 2 0 2002
CLAIMS DEPARTMENT

Remarks: _____

Total Disability means the patient is unable to perform all the substantial and material duties of their regular occupation.

Give dates of *Total Disability* (if applicable): From _____ to _____

If there were any dates of partial disability, please indicate: From _____ to _____

Date the patient is capable of resuming work: _____

Signature of Physician: Staffeld Date:	Physician's Federal I.D. Number: on file	Provider's Name, Address, Zip Code: Ochsner Clinic Foundation 1514 Jefferson Hwy New Orleans, LA 70121
Printed Physician's Name: Catherine Staffeld-Coit, MD	Patient's Account Number: CL#1637626	Phone: (504) 842-3000 Fax: ( )

EMPLOYER'S STATEMENT

Date stopped work due to disability: / /	Name and Address of Employer:
Date returned to work: / /	Signature of Official Representative: Date: / / Phone: ( ) Title:

75-1911 (9/01)